The struggle for the social: rejecting a false separation in our engagement with 'social' worlds in mental health spaces

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Abstract

How are we to best conceptualise the social in relation to mental health? This piece seeks to explore a series of tensions that emerge in our attempt to contemplate, engage with, and address the social in mental health spaces. First, I explore the tensions created by disciplinary demands for specialisation, questioning the value of this in with regards to treating the social and emotional body, which continually rejects this fragmentation. Drawing on the work of Foucault and Deleuze, I re-interpret a case study of a woman seeking mental health services in South Africa, initially encountered during my doctoral research in 2010. In doing so, I also explore the tension created by seeking to hold the complexity brought to systems and researchers by everyday people, within spaces for response and action. To move the field forward, I explore the need for, and simultaneous impossibility of a ‘unifying theory’ which contains the multiple ways that the social manifests. In developing these arguments, I reflect on what possibilities for a unified perspective of the ‘social’ provided by phenomenology embedded in Black Sociological scholarship, which reminds us that our understandings and ways of being in the world are situated within and against the life world. This approach more readily offers access to the full range of the ‘social’ that we often seek to differentiate for the purposes of analysis or manageable systems of response. Though what this means for global mental health approaches is arguably still to be determined, I conclude with a potential call to action that asks us to develop maps of the social, which allow academics, activists, and practitioners to better engage in processes to recognise the constellation of social dynamics at work in people’s lives.

Full Text

Introduction

Towards the end of my doctorate, I had a moment of crystallization where I finally understood why many of my peers studying health within the social sciences, could not see, what I saw. During a session where I described my vision for the future of global health interventions, I was attempting to describe what models of care should look like to bring them in line with the voiced needs of women living through adversity.

Following my presentation, a colleague said something along the lines of the following:

“well to me, your interests and the interests of women themselves, are rooted in the socio-structural, and it seems that current services are designed with more interest in the socio-relational dynamics of wellbeing – you are asking us to focus more on the former, in response to an over emphasis on the latter”.

My immediate response was one of confusion. I could not see what exactly is gained from a separation of the social. What do we objectively and practically gain from identifying one aspect of someone’s life as socio-relational, another as socio-structural, another as socio-biological? Especially when to that person, social impacts and processes are often woven in and through each other in ways that rarely separate so easily?
This was the beginning of years of questioning which has shaped my work for the last decade. It has always appeared, and remains to me, a falsehood, for scholarship to separate into component parts, what women themselves view as enmeshed, entrenched, and indivisible aspects of their lives. A process that has been also criticised by others [1]. In the 15 years that I have conducted qualitative research on women's mental health, narratives were never ‘socio-structural, or socio-relational, or socio-political’. They were all these things, all at once. Yet we exist in platforms where systems designed to understand the realities of social beings, cannot meet them where they are in this complexity.

In a Lancet Psychiatry commentary published in 2020 [2], I suggested that “global mental health” continues in the legacy of wider psychological and psychiatric discourses, by over emphasising the socio-relational in mental health, to the exclusion of other notions of the social in planning and structuring the parameters of interventions. Psychological therapies, focus on emotional, relational and cognitive framings that determine how we interrogate, respond to, and navigate social worlds. Psychiatric treatment focuses on the potential establishment of biological equilibrium created by hormonal and neurotransmitter imbalances associated with various forms of disorder with the aim of resorting good mental health, defined broadly as experiencing meaningful function within one's social worlds. However, evidence illuminates the difficulties for achieving such outcomes. A recent study showed high remission rates experienced across numerous age groups and types of psychiatric medicine for conditions like depression types [3] suggest that through these pathways alone, we will not reach our desired ends. For a burgeoning movement for global mental health, the result is crystalised in the closing remarks of former UN Special Rappator Puras in 2021, where he states frankly that the global mental health response is:

“not focused on how poverty and social injustice can produce mental distress. The focus has been on the burden and cost of mental health disorders. That is not consistent with a human rights-based approach and has been shown to be methodologically flawed. The focus remains on individual rather than systemic change as a means of tackling poverty and oppression.” [4]

The result has been the creation of necessary but insufficient spaces that, at best, create more cumbersome pathways for the recognition of full social worlds. At worst, it leads to a denial of the importance of the world where bodies live while prioritising only certain aspects of care.

The remainder of this piece, seeks to explore a series of tensions that emerge in our attempt to contemplate, engage with, and address the social in mental health spaces. First, I will explore the tensions created by disciplinary demands for specialisation, questioning the value of this in with regards to treating the social and emotional body, which continually rejects this fragmentation. I reflect on the case study of a woman encountered during my doctoral research in 2010 which has remained with me for many years, originally analytically in 2016 (See [5]).

In my final section, I explore the tension created by seeking to hold the complexity brought to us by everyday people, within spaces for response and action. Here, I explore the need for, and simultaneous impossibility of a ‘unifying theory’ which contains the multiple ways that the social manifests. In developing these arguments, I reflect on what possibilities for a unified perspective of the ‘social’ provided
by phenomenology [6] which reminds us that our understandings and ways of being in the world are situated within and against the life world, which is constituted by the full range of the 'social' that we often seek to differentiate for the purposes of analysis or manageable systems of response.

Though what this means for global mental health approaches is arguably still to be determined, I conclude with a potential call to arms that asks us to develop maps of the social, to allow academics, activists, and practitioners to engage in processes to recognise the constellation of social dynamics at work in people's lives.

The body must testify: tensions in unpacking the reality of the social?

Psychiatric knowledge production, in line with much of its related health disciplines, is rooted in and sustained by an acknowledgement of the biological at work to shape the psychological. In his Archaeology of mental health [7], Foucault draws our attention to the ways in which psychiatry must attain/obtain it's status within the health discipline, through performance that draws attention to, and mirrors the logics of biological medicine/sciences. The reasons for this work, are rooted the wider social contexts of this period; psychiatry in its early years was a medical specialisation that was linked to the stigmas that patients carried (though of course, patients endured the blunt end of these social rejections). For psychiatry to shed these social judgements, and to obtain the markings of respectability, required a systemisation of its practices, a mechanisation of its approaches solidifying in its respectability within the sciences (see [8]). This mechanisation has resulted in a psychiatry that runs in parallel with biological sciences – with various sub disciplinaries and specialisations that narrow its focus to specific aspects of the body (such as Neuropsychiatry), stages of our lives (Adolescence and older age) or experiences (addiction or rehabilitation).

One of the major critiques that psychiatric and mental health practice has grappled with, is its capacity and ability to acknowledge the social dimensions of patients' lives. Within the 13 specialisations listed on the Royal College of Psychiatrists website, only one of them makes explicit mention to the social: Rehabilitation and social psychiatry – which is focused on supporting recovery and reintegration of people with long term, complex psychiatric conditions back into the community. Social science-based critiques of psychiatric practice are most often anchored to demands for the social – seeking to illuminate how much of what counts as a 'good life' are rooted in social factors [9]. While necessary, and responsible for having driven many adaptations within psychiatric and mental health approaches to treatment and care, is it worth exploring what is lost and gained in this type of approach to marshalling our critiques?

In contributing to a response to these questions, I have been drawn to Deleuze's [10] accounts of Foucault's work, specifically his accounts of Foucault's approach to the archaeology of discourse. Archaeology as Foucault applies it, is the process of grappling with the origins of a concept or idea (or knowledge) manifested as 'statements' in our speech and writing and discourse. In his approach, what is often taken for granted, or assumed, is interrogated to investigate its roots. Deleuze suggests that that during this process, we can begin to think about the spaces that exist around discourses/statements,
which allows us to observe how claims about what is or isn’t included in our conceptualization of ideas only gain their meaning and value through context or situated realities. For example, when the idea of the social is invoked, it establishes relationships to subjects, objects, and concepts which create and mean things to serve specific ends.

If we apply this to the notion of the social as it is expressed in the social sciences, we are confronted with repetitions of nearly identical formations, which shift depending on contexts in which they are uttered. A rapid exploration of some common iterations of the ‘social’ via their dictionary definitions, results in a series of slightly repetitive statements, as outlined in Table 1.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>Socio-relational</td>
<td>voluntary or interpersonal relationships between actors, groups, organisations that exist within social structures</td>
</tr>
<tr>
<td>Socio-political</td>
<td>relating to or involving a combination of social and political factors (social structures that are shaped by political policy, practices and social behaviours)</td>
</tr>
<tr>
<td>Socio-economic</td>
<td>relating to or concerned with the interaction of social and economic factors (social structures that are shaped by economic policy, practices and behaviours).</td>
</tr>
<tr>
<td>Socio-structural</td>
<td>relating to the social structures of society, often linked to five levels of analysis from western European sociological scholarship – the structure of the family, law, religion, economy, class</td>
</tr>
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Here we can observe the slight repetition that occurs across the use of these terms, the slippage of their boundaries. The socio-economic is also the structural – the socio relational can also be structural, when for example, you are exploring relationships within the family structure. Deleuze suggests that this repetition is only possible because repetition begins to direct us toward the single definition that precedes the statement – which exists somewhere in our collective consciousness. The possibility of a core notion contained within the statements in Table 1 lends itself to the possibility that we can approach the ‘social’ as topological, rather than a typological concept. Topologies, which are rooted in mathematics, push us towards recognising that within certain entities there are potentially infinite combinations and iterations that can emerge from the original concept. Crucially, even as a topological shape shifts and transforms into alternative iterations of the original, its core proprieties are maintained and preserved. Thus, topologies exist as structures which allow for the definition of continuous formations and reformations of subspaces, and ultimately multiplicities of a central notion. With topologies, even as things change, they maintain their core; they stay the same [11].

What would applying this mean for our attempts to grapple with the ‘social’ for global mental health? Scholars in the social sciences more broadly appear to negotiate within the space of the social by breaking it into constituent parts and creating typologies. They enable analytic tasks and allow for refining concepts, as well as the creation of categories for measurement, classification and sorting of
Thus, the aim of typology is to divide, as part of generating understanding. However, everyday bodies experiencing and making sense of the social don’t as readily break it up into its constituent parts - for them, it is always a part of the same form. You can’t talk about health without talking about family, without talking about the state, or economics.

Perhaps viewing the social as a topological space, where these realities entwine and transform each other, rather than work independently, brings us closer in line with how bodies experience the multiplicities of a social space. By orienting ourselves to how bodies located within the totality of a social space, we can have a meaningful and localised understanding of how and what the social means, which can have direct impacts on our responses. In a 2016 piece [5] published about the realities of mental health systems in south Africa, I explored the case study of patient S. In reading this case more than a decade later (see Box 1 below), the simultaneous and multiple spaces in which the social operates for this woman emerge.

Box 1: Case study: (Burgess 2016)

Female (S), Age 54 Social history: S described a long history of problems with her ex-husband. He abandoned her, which resulted in the loss of custody of her children. She experienced depression and sadness related to the loss of her children. Depression did not respond to counselling sessions with the social worker on staff. She continues to argue with her children about them not supporting her – she currently has no job and no income. Medical history: S was prescribed haloperidol (by community nurses) to manage audio hallucinatory symptoms (hearing voices) in 2006. When asked to describe what the voices say, she was unable to be very clear – and stated that that she can’t really identify what they are assaying but it comes across like they are preaching to her. She says that she also feels an ‘electrical shock’ that isn’t scary to her, but that’s’ what she feels when she hears them. Chart notes: (history from visiting psychologist from 2006, prior to initiation of haloperidol). The psychologist describes that S’s obsession with the grant is something that will only exacerbate her symptoms, but that he didn’t feel that she warranted receiving it at that time. M (Psych nurse) notes assert that based on the psychologist’s findings that she may be malingering to gain access to a grant. Presenting issue: Her current complaint is linked to problems with her memory (forgetting where she puts things) and on-going psychosocial depression that is related to her unemployment, lack of support systems and on-going difficulties in accessing a disability grant. She described her most recent attempt to apply for a disability grant, which involved an encounter with the signatory doctor in the social welfare department who claimed that she didn’t need a grant, she needed a boyfriend. Although she doesn’t describe side effects from the psychotic medication that she is on, she asks – “If I’m not sick then why am I taking all of these medicines? And why do other patients who receive these medicines also get grants, but I cannot?”

Yet rather than being seen as a part of a unified whole, each aspect is partitioned off, handled by a different department who deals with her in slightly different ways; a doctor embedded within the social welfare department (who is responsible for opening gateways to socio-economic supports, and denies them). A psychologist who is willing to treat her medically, but only if her ‘obsession’ with the grant is, which would respond to the central pillar of her distress, can be pushed to the side. At the worst,
her interest in this response, is medicalised, identified as malingering. Her insistence that the entirety of personhood be seen, and be treated, is approached with frustration, and in some instances outright rejection.

The rejection and silencing she faces occurs at the intersections of multiple planes of social life.

Gendered norms, which stipulate that economic care should reside with a male partner (see [5] for this discussion), and socio-political norms; as the nature of the medical hierarchy ensures that those who are closer to the reality of her experience (nurses) do not have signatory power over access to the type of support she requires. Current solutions on offer within the global mental health canon, do not readily support the development of responses that are sufficiently social or complex. Our response struggle to resist the erasure that stems from the overs-specialisation that comes from our typologies of the social. This reality drives us to another tension created by our current engagement in with the social; that its fragmented nature drives us to participate in the act of ‘unknowing’, in order to respond to the complex narratives embodied within and by patient experience. So the field is at once, demanding patient involvement, and turning away from what patient involvement demands. This feels reminiscent of Deleuze’s reflections on knowledge in the context of multiplicities: “But one also sees, then, how certain multiplicities, and formations direct the knowledge... haunting them not towards epistemological thresholds, but in very different thresholds.”[10, p. 18]

The directions knowledges push people in, have specific, and different consequences in care vs. academic spaces. In terms of care/treatment spaces, the above case example illuminates movement in very different directions for a patient. Her family difficulties and depression require support from a psychologist, and to be pulled in this direction means that she must leave behind worries of the social-economic life. Addressing the socio-economic require referrals to social work office, pulling her into another threshold and different systems of operation. Neither of these thresholds reach the other social dynamics at work. Her relationship difficulties are embedded within generational poverty, gender inequalities and harmful norms that work through hierarchies. These problems are anchored to a predominantly vertical response (single-condition focused) strategy, where horizontal and traversing problems persist. This is a long-standing critique facing much of modern global public health – for example the HIV response was widely criticised for this strategy [13]. Despite this, the global mental health field adopted this strategy as their own, inheriting some of their mistakes. Interventions move forward with singular foci (or in some cases, co-morbidities) of conditions.

Within academic spaces, social context is largely engaged with through the acknowledgement and exploration of how social contexts (and occasionally their interactions) influence the delivery and implementation of interventions. As arguments remain for ‘gold standard’ evidence, there is a process of reproduction that pulls academics towards certain forms of storytelling about people’s lives. Less attention is given to how social contexts emerge, intersect, and show themselves as ‘multiple’ in people’s lives. In recently published work exploring the contexts of emotional distress for female victims of the conflict in Colombia, we found that women’s narratives were multiple – quite similar to what I saw years
earlier in South Africa. Women were exposed to multiple violence(s) – and in this exposure, reflect the multiplicity of the social. The conflict, the direct vector of physical forms of violence in women's lives, is anchored to socio-political and socio-structural dynamics, a conflict rooted in unequal land distribution, the marginalisation and exclusion of rural, indigenous, and black communities [14]. In attempting to articulate and hold on to women's complexities in telling of their stories, I fought against reviewers who called for us to divide the paper into various parts, calling for a focus on motherhood, OR the political economy of violence, OR mental health – but not the intersection of these three issues. It was a battle, to leave women's to ensure that women's voices could assert the multiplicities at work in their lives.

I have gathered the testimonies of women and others who call us to acknowledge that the social is best approached as this space of multiplicities. And over the past decade, I have watched disciplines and practitioners struggle to view this evidence as valid, meaningful, or actionable. In recent writing by UK psychotherapist James Bam, he articulates that in the attempts of psychiatry to grapple with the social – in part due to the creation of a biopsychosocial paradigm, social causes have been recognised, but the allegiance to biomedical or specialist responses remain to this [15]. What is the point of a field that acknowledges the social, but then outsources it responsibility? How do we move our research and practice towards a space where we can witness and hold the testimonies like those discussed above in our responses? How do we counter the tendencies of specialisations and training which push us towards specific sub-categorisations, and the resulting erasures of lived complexity that result.

Responding to living evidence: Do we need a unified theory of the social?

Much like Audre Lorde I believe there are no new ideas waiting to save us. Only long forgotten ones. This possibility of a topology where the social world exists as a plane capable of continual reconstructions of a central core tenant is incredibly old, likely originating with the writings of Greek scholars. But the notion of the complexity and multiplicity of the social is not only embodied in European thought. In attempting to create analytical and response-oriented spaces that can respond to living evidence, we must rightly seek to integrate wider understandings of the world that are embedded in understandings that are as complex as those who survive and thrive within it. Particularly given the dominance of European philosophical traditions which push us toward separation and categorisation.

As a woman of Black Caribbean heritage with an interest in Black scholarship and theory, I am inspired by paradigms which speak to my own experiences of the world as this multiplicity of social dynamics and contexts. In my life, I have felt myself occupy a social plane where oppression or empowerment emerge as processes that ebb and flow. What is activated in a social relationship always depends on a range of local realities, linked to past, present and future; realities are simultaneously structural, relational economic and political. But is this mode of understanding the social transferrable elsewhere – and would it need to be?

In his writings on Black Sociologies, Carroll [16] draws attention to what he argues are core ways in which an African centred world views exist and present a ‘unifying’ social theory rooted in historical spaces,
places and ways of knowing. These are different to and separate from those anchored to European anchored knowledge systems which work towards separation. He writes:

*While the African world view prioritises an interconnected and interrelated reality that relies upon the immaterial aspects of reality to make sense of the lived experience and favours relations of the whole, the European worldview prioritises the separation of social reality, only utilizing that which can be apprehended with the five senses to validate and provide meaning for that which we engage through our lived experience* Carroll, 2014 pg 260.

The ‘worldview’ cited above was established by African American scholar Vernon Dixon, who suggests that sense making of our world is filtered through a series of philosophical assumptions about cosmology (the universe); axiology (values), ontology (ways of being) and epistemology (knowledge). The first two are argued as central to African-centred thought (see [16]), and lead to a major difference in understanding that knowledge is acquired through interconnected experiences and linked to structures that exist beyond the five senses (or that which can be observed).

The worldview has parallels with Societal Phenomenology, which suggests that experiences gain meaning through personal and intersubjective experiences that are projected against both a concrete and metaphysical space where life is ‘lived’ – the daily backdrop to our experiences [17]. Elsewhere I have argued about the value that such a perspective on the social provides for us, ultimately suggesting that it provides a pathway for developing a relevant and holistic understanding of mental health, which can be seen in much critical mental health scholarship (see the work of [18]).

However, what is so critical about a Black Sociological perspective, is that it responds to what others have argued was the intent of Schutz’s phenomenology – recognising that we must look beyond the ontological in our interests in phenomenological thought. According to Wagner [19] he stopped at an interest in exploring the epistemological – while Black scholarship like Dixon’s world view – draw on the totality of our world – including the cosmological and axiological. Furthermore, by suggesting global mental health adopt a Black sociological approach to understanding the worldview, I acknowledge a deficit in theorising about mental health (and health more broadly) in ways that are rooted in indigenous frameworks and structures of understanding. By asking our conceptual field to build maps of the social that include cosmology and axiology, it responds to the consequences of a field that excludes these crucial and often embodied dynamics of the social in people’s lives. In addition, it pushes the primary producers of knowledges (who are non-Black) to engage with frameworks of understanding knowledge, ontology rooted in the life worlds of the majority Black and Brown bodies that the field attempts to be about. This also speaks to the need to accept that both “science and poetry are both meaningful forms of knowledge” ([10], p 18).

Finally, my hope is that it will overcome limitations of how Schutz’s lifeworld concept has been applied, which I see manifest in an underappreciation of power dynamics at work in the actioning of knowledge generated from mapping of life worlds. Schütz [6] contends that actors have:
“a common surrounding to be defined by [a] common interest... To be sure [they] will have a different knowledge of the common surrounding, if for no other reason than that [one] sees it from ‘there’ and everything that [other] seeing from ‘here’. Nevertheless, [one] may, within this common surrounding and within the zone of common interest, establish social relationships with the individualized other; each may act upon the other and react to the other's action... the other is partially within my control, as I am within his (p.471).

If this is the case, Schütz appears to assume all actors to have equal capabilities to inform actions. But as we know, recognising a shared platform is not an easy task. Global mental health’s problems are rooted in the reality that all actors do not have equal access to knowledge production [20] nor are their contributions to knowledge production valued in equal ways. This inequity in real and often practical terms that exist within treatment AND research spaces, results in particular aspects of the world view being more emphasised than others, which is a problem in global health more widely [21]. In this way, we are reminded of the near impossibility of a shared platform within the life world – as we each engage with it in ways that are shaped by our varied ways of being in the social world, and our access to power within our worlds. This tension presents the largest challenges to the application of a unifying theory of the social. Ultimately, positioning the complexity as a social topology, or the worldview, demands asking others to engage in a process of mapping the realities and totalities of these planes in people's lives. Whatsmore, when this mapping is complete, enacting this complexity will likely be constrained by the other individual projects of other actors, with proximity to greater positional, economic and structural power than patients or communities. There is no methodological or treatment solution to this – but perhaps a value driven one, which calls for a compassionate and action-oriented listening. Even so, this will not automatically lead to addressing the tangible impacts of the social in the lives of those who experience mental distress, even though they demand it.

Perhaps our call to arms when it comes to the social, is a commitment to mapping and recognising these tensions, rather than turning away from them. New orientations will allow us to recognise complexity, but the challenge will be to do so without the insertion of hierarchies or giving into the seduction of the ‘one’ way to define the social in people's lives. Perhaps the work remains, for us to establish ourselves first, and always, as archaeologists of the social – working along whatever topological form matters most to those we engage with. In this way, acknowledging that this will always be, and must always be different, and to confine ourselves to work which seeks to reduce the social, will always be insufficient.

Declarations

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4. UN, “Final report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” 2020.


